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Manitoba's Clinical & Preventive Services Plan

Investing in Better Care, Closer to Home

SENIORS AND REHABILITATION PROVINCIAL CLINICAL TEAM

Clinical & Preventive Services Plan Summary

An opportunity to elevate outcomes through reconfiguration

Manitoba's key population characteristics create an opportunity for the province's health system to both **meet evolving needs and set the standard for care in priority areas including rural health, healthy aging, and needs of diverse populations.** The significant **Indigenous population** presents an opportunity for leadership in **collaborative design and delivery of health services**.

Key Population Characteristics

Manitoba's Population is Growing

Growth rates vary by region with **higher growth in Winnipeg and Southern regions**, by 45% and 62% respectively, over the next 25 years.

Manitoba is Highly Rural

44% of the population is **highly distributed across geographies** with less than 10 people per km

Manitoba has an Aging Population

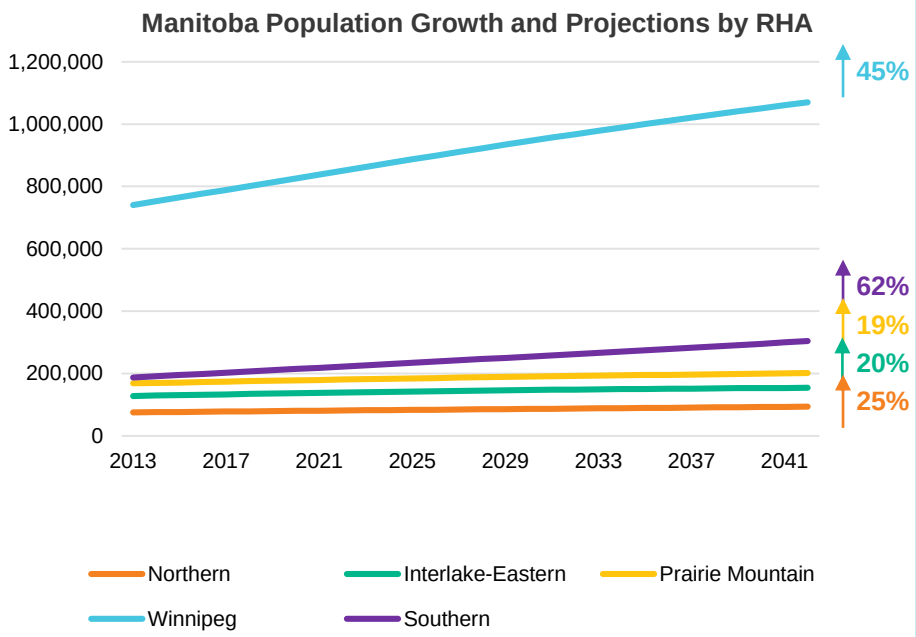
The **largest growth** is projected to occur with the **80+ and 60-70 year old cohorts** however Manitoba remains the only province where youth under 15 exceed the older population

Manitoba has a large Indigenous population

Manitoba's Indigenous population makes up **18% of the population**, the highest of any province in Canada. This population is also younger than the rest of the province

Manitoba has a Diverse Culture

109,925 Manitobans speak French of whom 74% were born in Manitoba. **18.3% of Manitoba's population are immigrants** with 80% settling in Winnipeg



A strong foundation to build upon

Manitoba already holds **capabilities and characteristics** that can be leveraged to enhance the future healthcare system

One provincial academic hospital

The majority of tertiary health services for Manitoba's 1.3M people are delivered in Winnipeg through one provincial academic hospital: Health Sciences Centre (HSC), an internationally recognized and accredited academic hospital and research centre.

A leading university and research centre

University of Manitoba is a leading centre for the training of health professionals and support for specialist care delivery and rural and urban primary care.

International leadership role in the health of First Nations, Metis, Inuit, and Indigenous Communities

- Leadership role in instituting Jordan's Principle – a Child-First Initiative to assure equitable access to essential care
- Internationally recognized partnership-based health research through Ongomiizwin - Indigenous Institute of Health and Healing

Adaptability to innovative models of care

37% Increase in MBTelehealth utilization over in the past five years and multiple modes in place

1m+ miles saved — By clients who visited the Mobile Clinic (primary care bus) over five years in Prairie Mountain Health

Multiple achievements to improve wait times and patient experience

25% Improvement in total time spent in Winnipeg EDs (Winnipeg) – the most improved in Canada

50% Improvement in total wait time for endoscopy through centralized referral and intake models – similar models in place for hip and knee replacements, spine surgeries, and others

Flexible workforce options provide new opportunities to build future models of care

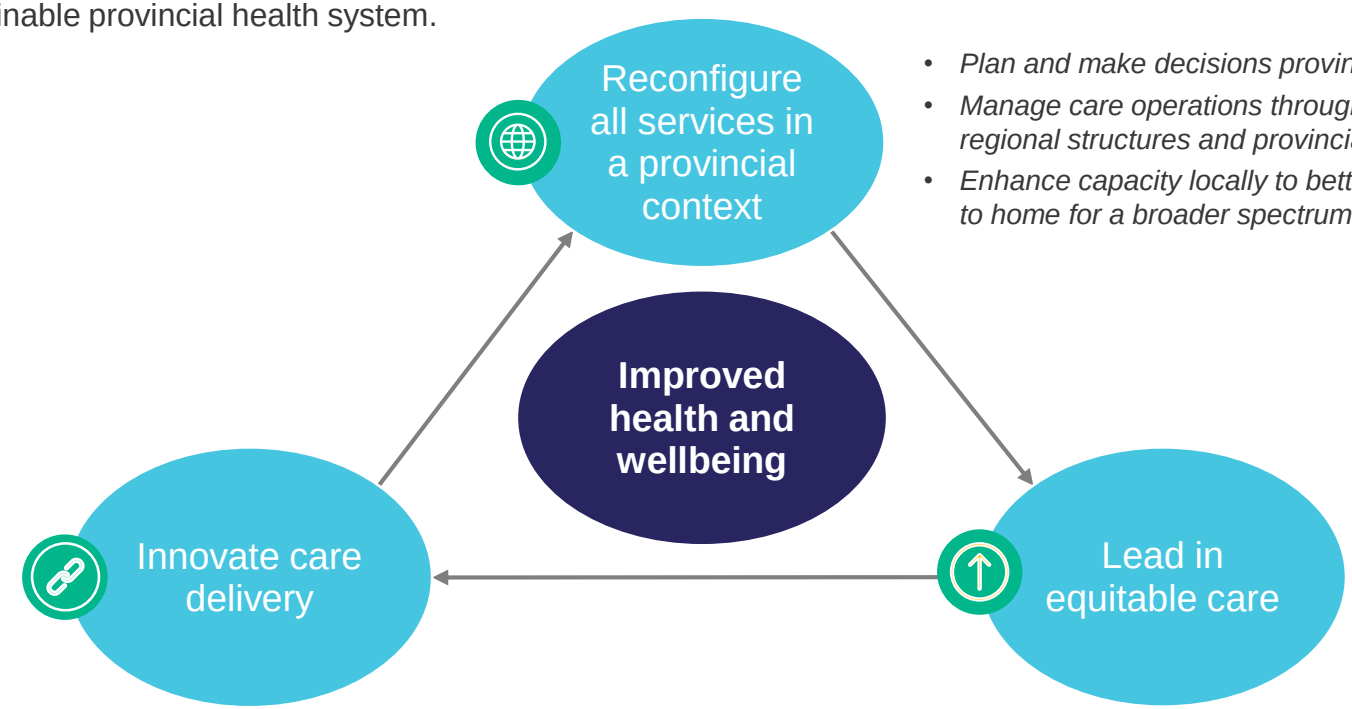
2x More paramedics per 100,000 residents than the Canadian average and more female paramedics (national average: 32%)

20+ Regulated health professions under one umbrella act (*The Regulated Health Professions Act*) with 21 categories of reserved acts

Expanding scope of Nurse Practitioners (e.g., minor invasive procedures, ordering diagnostic tests). Long standing leader in training, education, and employment of physician assistants including into primary care.

Manitoba's bold new future: Reconfiguring For Better Health and Wellbeing

The **elements of the future vision will work together** to improve how the health system supports Manitobans. Through redefined access and service capabilities across the province, Manitobans will benefit from improved health outcomes and a more sustainable provincial health system.



- *Plan and make decisions provincially*
- *Manage care operations through a combination of regional structures and provincial services*
- *Enhance capacity locally to better support care close to home for a broader spectrum of health needs*

- *Provincial clinical governance to support clinical practice and model-of-care improvements province-wide*
- *Modernize care delivery approaches to increase reach and access from a patient and provider perspective*
- *Innovate* how *care is delivered to achieve better health and broader outcomes*

- *Lead in equitable care to urban, rural and remote communities through connected care*
- *Commit to a new future for Indigenous health in Manitoba based on a collaborative model of co-design and enablement among Indigenous communities and the provincial health system*

What does a modernized health system mean for individuals?

TODAY

- **Knowing where to go for the right care can be confusing** – for patients and for providers
- Your health care provider **may not have all the necessary information** about you and your health – this can result in you having to tell your story over, and over, and over again
- You may wait a **long time to access** the right care including diagnostic services and specialist care
- The care you need may not be accessible close to home, **requiring you to travel** to access services
- Your **visits may not be coordinated** across care providers, resulting in multiple trips to access care

IN THE FUTURE

- Consistent, reliable services will be accessible at facilities that are clearly defined by the care they provide, making it **easier to know where to go for care**
- Your health care providers will have **access to appropriate information** about you and your health needs
- Providers will **work together to coordinate** your care, ensuring that wherever you go, you are able to access the right care
- Coordination will **reduce your wait times** and unnecessary travel
- You will have the choice to **manage and navigate your own care**, in partnership with your primary care provider
- Your primary health team will have support to provide your **care closer to home** through virtual tools, advice and guidance

What does a modernized health system mean for individuals?

TODAY

Find a family doctor (primary care provider)
Wait for appointment to discuss your care needs
– or visit an Emergency Department

1st primary care visit

Specialist or diagnostic services referral and wait

Travel for care

1st specialist or diagnostic service visit

2nd primary care visit

Specialist or diagnostic services referral and wait

Travel for care

2nd specialist or diagnostic service visit

3rd primary care visit

Repeat referral and wait until an answer or diagnosis is determined

Travel for care

Ongoing visits to specialists and for tests

IN THE FUTURE

Providers work together to coordinate your care and multiple tools and options exist to help manage your own care

1st primary care team visit (providers with different skills work together)

You have tools to manage your health

You can get advice virtually

You have help to find the right health care

Your primary health team has the information they need about you and your health **and** has access to …

… advice and guidance for more specialized care needs that they can manage, with some support

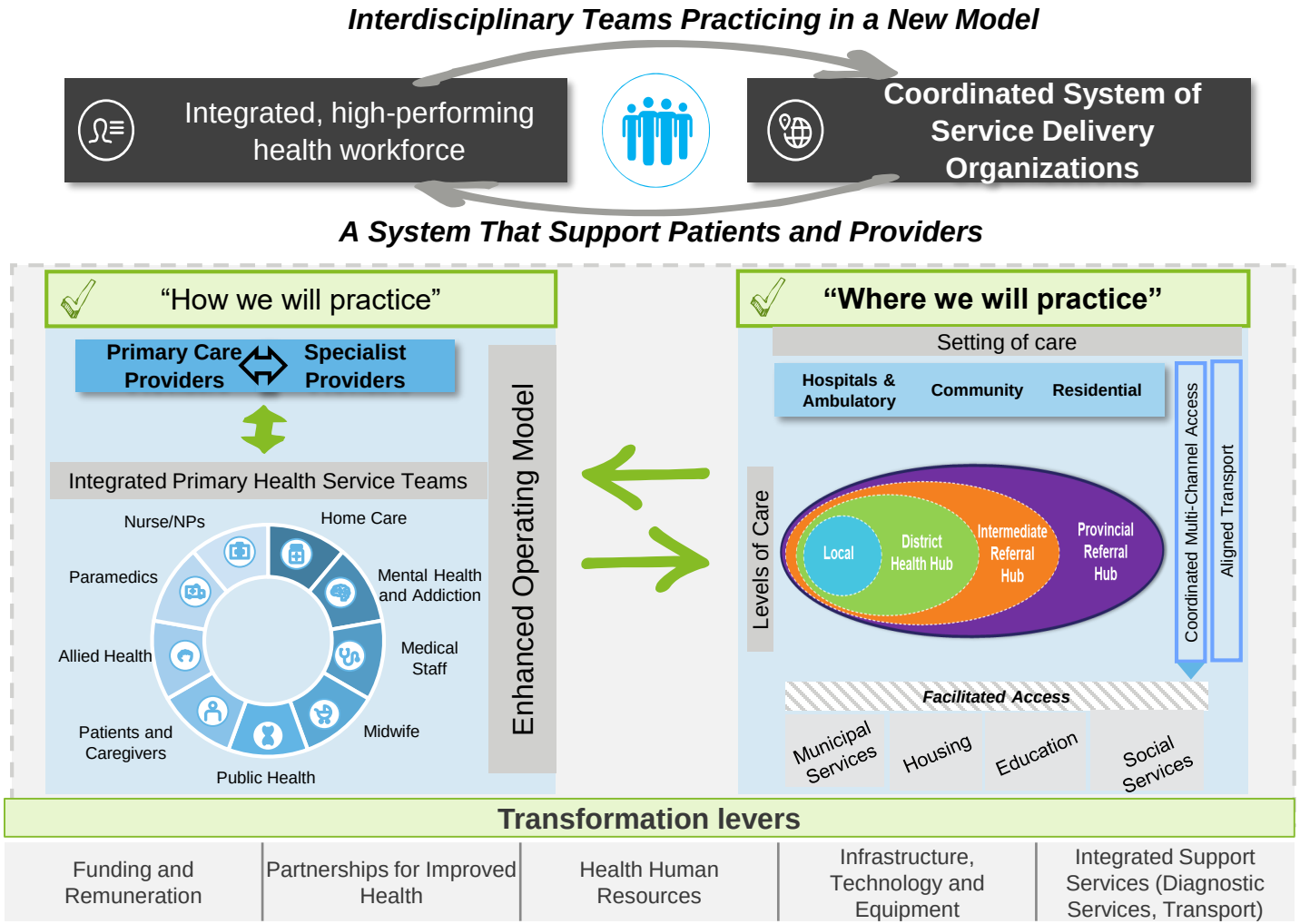
… virtual tools to bring care closer to home

… a network of other teams nearby for in-person or virtual access to care

… coordinated access to specialists that work together to reduce or eliminate unnecessary travel and coordinate with your primary care team

Each step in your care path seamlessly connects back to your local primary health team, keeping them up to date on your care

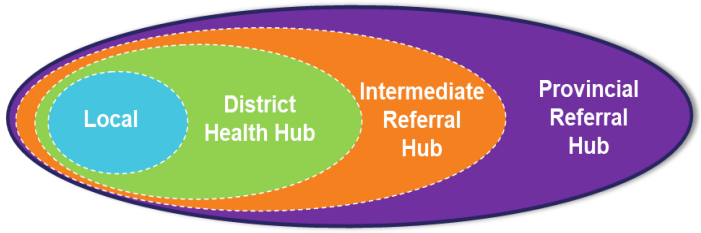
An integrated network for accessing and delivering services is core to the new provincial model



Defining one provincial system with enhanced local capacity and effective access to specialized care province-wide

The Integrated Network Model

- The Integrated Network Model shown below links local, district, intermediate, and provincial hubs and provides common service standards, capabilities and pathways for patients, providers and health system managers in the province.
- The model will reconfigure care to improve the health and well-being of all Manitobans through provincial standards that elevate care and innovative approaches to ensure equitable care delivery. The key to success will be the development of ***appropriate, sustainable*** capacity at the local level and ***standardized pathways*** that streamline how patients and providers navigate the system. ***Provincial clinical governance*** will guide the development and monitoring of standards and pathways. By leading in ***connected care***, Manitoba will optimize a hybrid digital and in-person care experience for everyone.
- The network model is intended to facilitate the relationship between providers and the flow of patients in the province. It is not intended to create barriers or "gates" in the system, instead it will be used to **create transparency and certainty of capabilities**.

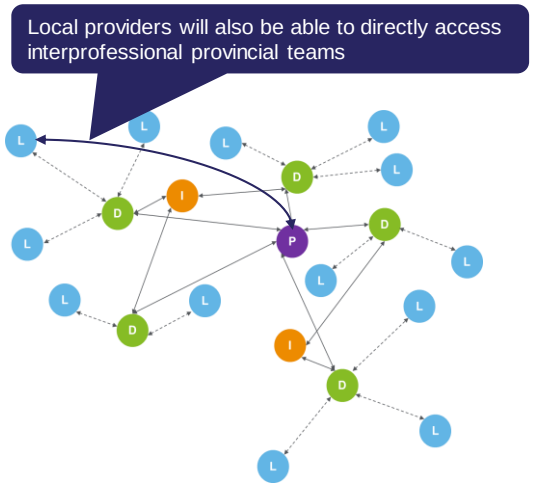


L **Local Area Hub**
Integrated network for prevention and screening, transitional care, community based support and rehab, and primary and community care

D **District Health Hub**
Integrated network for low-moderate acuity, variable volume general medicine/surgery interventions/procedures, post acute treatment and emergency services

I **Intermediate Referral Hub**
Integrated network for moderate acuity/complexity medicine, surgery, critical care, and emergency services

P **Provincial Referral Hub**
Provincial integrated network for high-acuity, highly complex medicine, surgery, critical care, and emergency services



Capabilities across local area hubs will be standardized along a spectrum, with flexibility to meet with population needs

The network model outlines ***minimum service standards and capabilities*** as the basis for infrastructure, health human resources, and clinical support services planning. Local Area and District hubs will feature a spectrum of capabilities (Enhanced, Core) to match the needs of its population, with increased acuity along the continuum from District to Provincial. Facilities at the District and Intermediate level may have targeted areas of programmatic focus that extend into higher levels of care.

Local	District	Intermediate	Provincial
Low acuity community-based care	*Low to moderate acuity community-based and inpatient care*	*Moderate to high acuity inpatient and medical/surgical care*	*High acuity/specialty medical and surgical care*

Enhanced

Interdisciplinary primary care teams who provide enhanced community services such as mental health support, midwifery, chronic disease management, and/or pain management; supported by appropriate diagnostics and the ability for short-term patient observation

Increased focus on **prevention and screening** with proactive population health management capacity

- My Health Teams, new care models (e.g., collaborative emergency centres in Nova Scotia, advanced care centres in Australia)

Core

Local primary care providers will be the main point of contact with the health system for most patients (e.g., Home Clinics)

Increased focus on **prevention and screening** with proactive population health management capacity

Core:
Urgent care during set hours for lower acuity patients

Enhanced and Intermediate:
24/7 Emergency Department

Provincial:
24/7 Emergency Department

General inpatient and ambulatory care with observation and monitoring capabilities, as well as targeted services

Enhanced:
Special Care Unit

Intermediate:
Intensive Care Unit (ICU)

Provincial:
ICU with specialized capabilities

Core:
Elective surgery, primarily with Family Practice Anaesthesia (FPA)

Enhanced and Intermediate:
Elective and emergency surgery with FPA or FRCPC

Provincial:
Elective and emergency surgery with FRCPC

Specialist Services may include:
District: Level I Nursery, community cancer care, primary stroke centre, and/or select areas of programmatic focus

Intermediate:
Level II Nursery, radiation therapy, general rehabilitation, moderate- to high-risk obstetrics and/or primary stroke centre

Provincial:
Intensive rehabilitation, and specialized mental health services, high-risk obstetrics and neonatal

Provincial Services such as:
Major trauma, thoracic services, comprehensive stroke care, specialty cancer care

Creating the capacity for a provincial approach to delivery in Manitoba through a 10-Point Plan

This 10-Point Plan outlines key mechanisms for Manitoba to improve access to care across the province and deliver on the benefits of moving to a provincial approach to care design and delivery

Interdisciplinary Teams Practicing in a New Model

Integrated, High-Performing Health Workforce

Coordinated System of Service Delivery Organizations

A System That Support Patients and Providers

"How we will practice"	"Where we will practice"
1. Provincial clinical governance	2. Clear roles and capabilities in network model
3. Enhanced community supports	4. Innovative approaches to care through digital health
5. Bridge the gap between primary care provider and specialist	6. Consistent pathways for targeted patient populations
7. Shift care between disciplines to enable clinicians to work to full scope of practice	8. Coordinated provincial access
9. Provincializing key aspects of our workforce	10. Provincial approach to outcomes and deliverables management

Seniors and Rehabilitation

Current state and case for change

Manitobans face challenges with equitable access to appropriate seniors and rehabilitation services across the province – there is opportunity to consider alternate modes and settings of care to improve access to limited resources.

Manitoba has implemented community programs/initiatives to support its growing older adults population

- Over the next 20 years, Canada's older adults population is expected to grow by 68%, with the population in Manitoba expected to increase two times its current size (CIHI, 2017)
- Manitoba has implemented several programs to support older adults in the community longer include Functional Independence Program, Home Independence Program, Priority Home, Program of Integrated Managed-Care of the Elderly (PRIME)

Lack of equitable and timely access to seniors and rehab care across RHAs, with many individuals waiting in alternative levels of care

- ~58% of older adults LOS in Northern is ALC (FY17/18), which is nearly double the provincial average at 32%
- An average of 3.5 days are spent waiting for rehab admission in WRHA, and an average of 9 days are spent waiting for discharge (FY16/17)
- Inconsistent types of specialized geriatric services across the continuum of care - Lack of appropriate units and care resources for special populations (i.e., specialized care units, behavior units, access to mental health resources)

Seniors Inpatient Admissions by RHA, FY17/18

	# Total Admissions	Average Total LOS	Average Acute LOS	% of Stay that was ALC
Manitoba	**28,265**	**18.1**	**12.2**	**32.2%**
Northern	538	24.0	10.2	57.6%
Interlake-Eastern	2,145	27.1	12.6	53.6%
Prairie Mountain	5,934	20.0	12.6	36.9%
Winnipeg	16,401	14.8	11.7	19.2%
Southern	3,247	25.0	13.7	45.2%

Source: MHSAL – Discharge Abstract Database

Limited access to rehab services close to home as a result of challenges in recruiting and retaining staff, and minimal alternative models of access available (i.e., digital/virtual)

- There is variation in the total number of FTEs across regions with 20,954 in Winnipeg, and only 1,671 in Northern
- There are 874 total physiotherapists in Manitoba, where 73% are in WRHA, 9% in SH-SS, 9% in PMH, 7% in IE and 1% in NRHA
- In FY17/18, there were 397 MBTelehealth sessions for rehabilitation, compared to 8,472 total oncology sessions, and 1,982 psychiatry sessions

FTEs across Regions, 2018

Region	Total EFT	Percentage	Ratio of FTEs to population
NRHA	48.4	3.6%	1: 1490
IERHA	41.45	3.1%	1 : 3080
PMH	143.54	10.7%	1 : 1150
WRHA	1029.71	76.4%	1 : 700
SHSS	84.43	6.3%	1 : 2270

Source: Shared Health

Current state and case for change

There are inconsistent processes for intake into settings of care, where many individuals are waiting in rehab beds or on wait lists – there is opportunity to establish provincial standards and navigation supports to ensure appropriate placement

Inconsistent processes for assessment, referral, triage, as well as gaps in alternate settings of care

- In WRHA, 15% of clients spent an average of ~20 days waiting for placement into residential care (PCH)
- In FY17/18, 3,496 individuals were identified as eligible for LTC placements, of which 32% remained on wait list at the end of that fiscal year
- 33% of Manitoba's older adults in the continuing care system show low to moderate needs and could potentially have remained at home with the appropriate supports
- Priority Home promotes home as the primary discharge destination and supports higher needs patients in the community including earlier discharge planning and centralized home care service

Long Term Care Wait List Volumes, FY17/18

RHA	Total Eligible Persons Paneled for Placement			Cumulative Total Number of Persons on Wait list ending March 31st		
	PCH	CC	SH	PCH	CC	SH
IERHA	394	24	47	154	14	69
NRHA	94	20	6	45	26	2
PMH	717	1	12	214	8	1
SHSS	376	0	75	302	0	41
WRHA	1334	60	336	136	14	95
Total	**2915**	**105**	**476**	**851**	**62**	**208**

Source: Provincial Summary, LTC Dashboard

Variable navigational support, clarity of available services, and variations in coordination of post-acute care

- In WRHA, over 2,200 days in rehab were spent waiting for home care and PCH

WRHA Reasons Waiting for Discharge, FY18/19

Reason waiting for discharge	Cases	Total LOS	Avg Total LOS	Active LOS	Avg Active LOS	Days Waiting for Admission	Avg Days Waiting for Admission	Days Waiting for Discharge	Avg Days Waiting for Discharge
Services - Home Care	203	9,816	48.35	8,703	42.87	603	3.11	1,113	5.48
Location - Residential Care (LTC/Nursing Home)	58	4,478	77.21	3,344	57.66	255	4.55	1,134	19.55
Other services	21	1,117	53.19	686	32.67	47	2.76	431	20.52
Personal - Informal Support	21	740	35.24	661	31.48	86	4.10	79	3.76
Location – Other	11	1,067	97.00	674	61.27	42	6.00	393	35.73
Home Modifications/Equipment - Equipment	10	434	43.40	360	36.00	36	4.50	74	7.40
Location - Assisted Living/Supportive Housing	9	607	67.44	395	43.89	31	4.43	212	23.56
Inpatient medical/nursing care	8	257	32.13	238	29.75	16	2.00	19	2.38
Personal – Other	8	439	54.88	364	45.50	50	6.25	75	9.38
Location - Transitional Care/Convalescent Care	6	306	51.00	255	42.50	8	1.60	51	8.50
Home Modifications/Equipment – Other	4	200	50.00	189	47.25	24	6.00	11	2.75
Location - Acute care	3	178	59.33	145	48.33	38	12.67	33	11.00
Location - Complex Continuing Care/Chronic Care	2	227	113.50	120	60.00	1	0.50	107	53.50
Location - Boarding House/Rooming House	2	101	50.50	94	47.00	1	1.00	7	3.50
Home Modifications/Equipment - Home Modifications	2	161	80.50	86	43.00	5	2.50	75	37.50
Services - Community Services	1	46	46.00	38	38.00	1	1.00	8	8.00
Unknown	1	20	20.00	19	19.00			1	1.00
Source: NRS	**370**	**20,194**	**54.58**	**-**	**-**	**-**	**-**	**-**	**-**

Current state and case for change

There is opportunity for Manitoba to establish provincial standards and protocols for select populations to reduce total LOS and ensure individuals are in the appropriate settings and closer to home, where possible

Inconsistent care delivery for select populations, resulting in long length of stay

- The average ALC % LOS relative to total for patients with dementia ranges across regions from 73% to 88%. This is much higher than the general senior population whose proportion of ALC stay ranges from 19% to 57% across regions.
  - This may be due to long PCH wait-times, a lack of appropriate resources for this population, and a lack of overall resources in the community to accommodate the needs of patients with dementia and behavioural challenges

Dementia Inpatient Admissions by RHA, FY17/18

	# Total Admissions	Average Total LOS	Average Acute LOS	% of Stay that was ALC
Manitoba	**1,012**	**44.0**	**10.1**	**77.0%**
Northern	37	17.4	4.6	73.7%
Interlake-Eastern	110	39.4	10.0	74.7%
Prairie Mountain	540	49.7	13.5	72.9%
Winnipeg	141	37.1	5.4	85.6%
Southern	184	40.5	5.0	87.6%

Source: MHSAL – Discharge Abstract Database

- The average LOS for inpatient rehab in WRHA is greater than the national median (NRS) across all client group types.
  - Note that national comparators may serve different populations which should be interpreted with caution.

Rehab Inpatient LOS by RCG, FY16/17

RCG Summary Group	Admissions (FY16/17)	Avg. WRHA LOS (16/17)	NRS Median LOS (16/17)
Grand Total	**1964**	**48.8**	**22**
Orthopedic Conditions	689	45.3	20
Stroke	287	54.3	29
Medically Complex	251	49.6	21
Debility	212	57.2	20
Spinal Cord Dysfunction	134	39.8	31
Brain Dysfunction	109	41.6	30
Pain Syndromes	48	40.7	17
Amputation of Limb	47	44.4	28
Cardiac Conditions	46	59.2	15
Arthritis	37	65.3	18
Major Multiple Trauma	32	55.9	26
Neurological Conditions	30	45.6	27
Pulmonary Conditions	27	52.6	20
Other Disabling Impairments	15	52.9	14 (Other RCGs)
Burns			27
Congenital Deformities			

Source: NRS, CIHI

Moving from today to the future

The vision for the future is based on evidence, informed by PCTs' holistic input, and aligns with jurisdictional practices

	Highlights of Current State	Highlights of Future State
Service Model – Highly Effective Teams	• Challenges recruiting and retaining staff to support rehab services closer to home • Challenges in the distribution of available therapy across the province, with variation in the distribution of total allied health FTEs across regions • Minimal use of telehealth for rehabilitation services	• Virtual delegated care models, including virtual group classes to improve access outside WRHA • Case coordinators to improve system navigation and access to appropriate services • Development of inter-professional collaborative teams with primary health (e.g., MyHT2.0) • Expand scope of work for select providers to enhance care giver support (e.g., Paramedics, rehab therapy assistants, allied health)
Service Standards and Pathways – Coordinated Delivery Systems	• Variable access to timely seniors and rehab care across regions, with many individuals waiting in ALC • Variable navigation supports and coordination of post-acute care • Inconsistent processes for assessment, referral, triage, as well as gaps in alternate settings of care • Inconsistent types of specialized geriatric services across the continuum of care • Promote dedicated education and training to prioritize elder friendly care and meet the needs of the growing population	• Standard coordinated access into seniors and rehab services and housing options across the Network, including in acute and post-acute, home care and PCH settings • Standard and shared assessments to ensure consistent and appropriate entry in housing supports, and to provide proactive intervention to prevent healthcare utilization • Alternative, affordable housing models to support individuals in the community longer and provide care closer to home (i.e., transitional care units) • Provincial expansion of existing programs to improve functional outcomes and keep individuals home longer • Central PCH wait lists accommodating equitable use of resources

Provincial view of the future vision

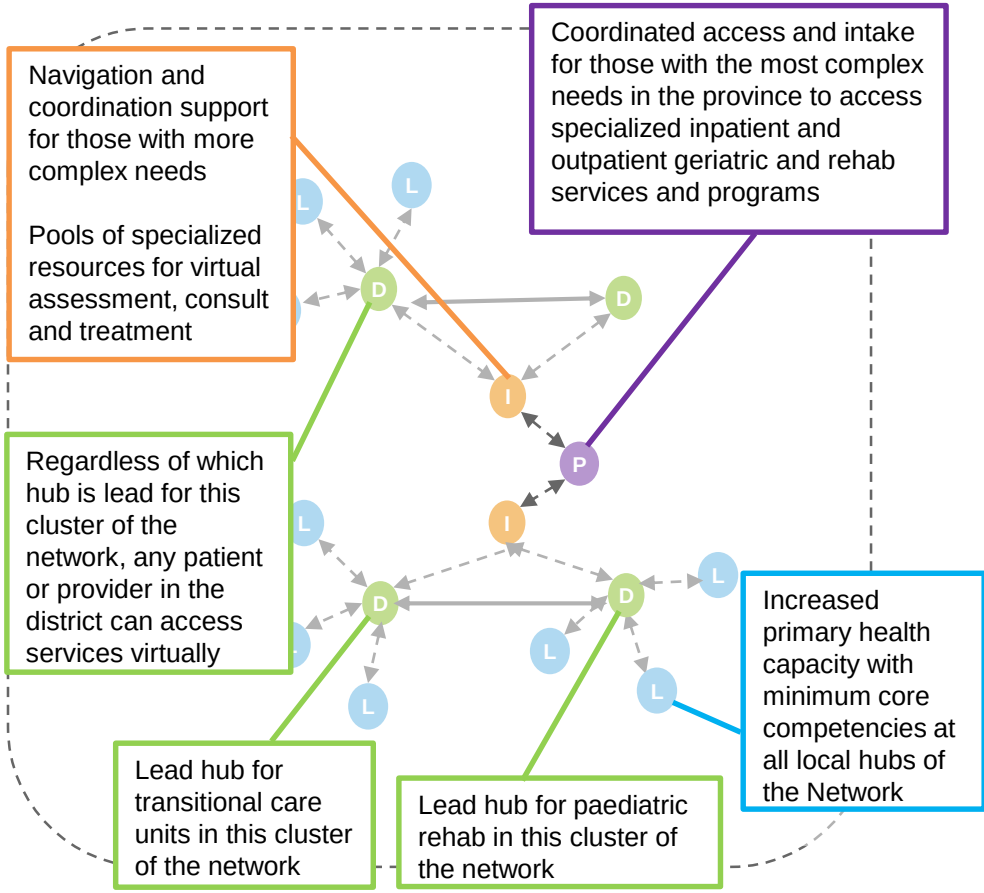
Future Vision: Manitoba will establish an integrated, coordinated system with linkages between all seniors related, and rehab related services. It is anticipated that the future model will result in:

- Improved access and coordination of seniors and rehabilitation services
- Appropriate placement into suitable environments, and individuals maintained in the community longer
- Improved primary health capacity to support service delivery closer to home

Key features of the future vision, include, but are not limited to:

- Sub-acute units to support older adults and rehab needs closer to home (including transitional care, convalescent care)
- Enhance capabilities at Local and District Hubs to provide coordinated care for lower complexity and healthy aging needs closer to home
  - Expand existing community initiatives and alternative housing models (i.e., Priority Home) to keep older adults home longer
  - Standard intake and assessment to ensure appropriate housing placement and coordination between settings
  - Promote dedicated education and training to prioritize elder friendly care and meet the needs of the growing population
- Standardize capabilities at Intermediate and Provincial Hubs for higher complexity needs
  - Blended coordinated intake and 'no wrong door policy' to increase coordination and access
  - Enhance capacity for specialized outpatient rehab programs (i.e., amputation, SCI, ABI, etc.)
- Virtual care tools to extend the reach of specialists outside WRHA and provide an alternate mode of assessment and consults (i.e., virtual delegated care)
- Consistent tools to support system navigation across the continuum (i.e., online tools for self navigation, enhanced role of care coordinators)

Illustrative example of network hubs working together



Service standards | Seniors

	Service standards
Provincial Referral Hub	• Provincially coordinated system for assisted living and supportive housing to ensure consistency across settings of care (i.e., home care, PCH) • Coordinated intake and access to standardized and specialized older adults supports for higher need patients (e.g., WRHA Geriatric Rehab program, gerontologist, geriatric mental health teams) • Standardized pathways for older adults, including standard frailty scales to identify frail older adults • Standardization and proactive stratification of older adults by complexity, acuity, and risks (e.g., for dementia, falls, medication) using standardized assessments (i.e., Inter-RAI)
Intermediate Referral Hub	• Coordinated inpatient geriatric rehab needs, geriatric mental health needs, and assessment unit for frail older adults • Specialized geriatric units for less complex older adults with collaborative care models (i.e., Acute Care for Elders units, geriatric mental health units, geriatric rehab)

District Health Hub	• Virtual access to expertise at Intermediate/Provincial Hubs, including e-consults and virtual care
	• Provincially consistent services and standards across settings for specialized populations (i.e., dementia, behavioural challenges)
	  • Specialized care units/behavior units with consistent access to mental health resources (e.g., psychologists)
	• Sub-acute care units, including convalescent, post-acute and transitional care, to support individuals closer to home
	  • Includes rehab therapists to support transitions to the community and home
	• Coordinated intake and access to specialized community skill building programs (Functional Independence Program, Home Independence Program, Priority Home/Pathway to Home) including virtual access

Local	• Alternate housing models and provincially standard intake and design of PCHs to support access and appropriate care delivery
	  • Standard assessment to ensure appropriate panel
	  • Co-locating of individuals with similar conditions to support independence and improve patient outcomes
	  • Minimum level of knowledge and education for providers in community
	• Standard dental prevention and screening across settings of care
	• Community programs to provide services for older adults support wellness and healthy living (i.e., Meals on Wheels, Falls Prevention Program)
	• Enhance homecare through home and remote monitoring technologies and through community skill building programs
	• Provincial expansion of Rapid Access to Consultative Expertise phone lines to build primary care capacity in the community
	• Support structure for patient's families to keep patient's closer to homer for longer periods of time (e.g., Dementia care giver support)

Provider roles | Seniors

	Provider roles
Provincial Referral Hub	• Specialized geriatric expertise at Provincial Hub to provide in-person and virtual education outreach and virtual consultations to other hubs in the Network • System navigators/care coordinators for those with more complex needs
Intermediate Referral Hub	• Specialized geriatric expertise at Intermediate Hubs, with education outreach and virtual consultations to District and Local hubs
District Health Hub	• Outreach teams including Geriatric Program Assessment and Geriatric Mental Health Teams to support care in community to reduce patient travel (e.g., for frail older adults) and provide follow-up and assessments for programs or services • Shared Care models with geriatricians and primary care providers to provide comprehensive geriatric care in the community (i.e., enhanced MyHT) • Promote dedicated education and training to prioritize elder friendly care and meet the needs of the growing population

Local	• Integration of older adults care into enhanced MyHT to act as a “hub” for patients in their home community to enhance local access for older adults needs and reduce need for travel
	  • Integration of allied health, psychologists/psychiatrists, and GPAT teams
	  • Integration of priority home and home care
	  • Enhanced linkages with community partners

Service standards | Rehabilitation

	Service standards
Provincial Referral Hub	• Consistent virtual tools to support specialized rehab practitioners to provide access across the Network • Coordinated intake and access and to specialized rehab programs/care teams (e.g., ABI, Amputee, NMSK, SCI, Stroke, etc.) including standard comprehensive assessment pre-admission to ensure appropriate placement • Standard criteria for referral and intake, and consistent awareness on admission criteria for specialized rehab programs • Specialized outpatient rehab clinics for select populations (i.e., amputation, stroke, failure to cope) • Provincial resource to view available resources and best practices across province
Intermediate Referral Hub	• Coordinated intake and access to rehabilitation programs/care teams • Supported flow of long-stay patients back to community, with ongoing rehab supports • Outpatient rehab clinics for special populations to reduce unnecessary admissions
District Health Hub	• Transitional care units to support patient care once rehab needs are met, to reduce bed block of patients waiting for housing placement • Virtual access to expertise between the facilities at other hubs, including e-consults and virtual care • Standard placement (i.e., transitional care units) for patients who do not meet rehab or PCH admission criteria • Access to specialized mental health resources • Expand existing skill building programs (i.e., Functional Independence Program, Home Independence Program, Priority Home) to get individuals back home sooner
Local	• Use the learnings from Jordan's principles and improve access to Indigenous Communities • Virtual access to specialized expertise at Intermediate and Provincial centres, including e-consults and virtual care • Technology enablement to provide home and remote monitoring, and virtual assessments • Consistent access to rehab services across settings of care, including home care and long-term care (e.g., programs available after-hours) and therapy assistants • Online tools to support self navigation for lower complexity clients in bilingual services

Provider roles | Rehabilitation

	Provider roles
Provincial Referral Hub	• Specialized rehab expertise, including OT, PT, SLP, Audiology , Pharmacy and Social Work at inpatient and outpatient Provincial centres, with education outreach and virtual consultations and assessment to other hubs in the Network
Intermediate Referral Hub	• Rehab therapists including OT, PT, SLP, Audiology and Social Work at Intermediate centres to support moderate and lower complexity clients and provide education outreach and virtual consultations and assessments to District and Local hubs • Case coordinators to support system navigation for patients who require multiple specialists and travel to patient when necessary
District Health Hub	• Multidisciplinary teams (e.g., allied health and primary health providers) to provide community based rehab programs • Cross training of non-regulated health professionals, including home care and rehab assistants (via remote and telehealth or in person) to increase access to rehab and to better support specialized populations

Local	• Integration of allied health and home care providers with enhanced My Health Teams to act as a “hub” for patients in their home community to enhance local access for rehab needs and reduce need for travel
	• Enhanced capabilities of primary health providers through continued training and education (e.g., training home care assistants at other hubs in the Network)
	  • Cross-training of non-regulated health professionals, to improve access to rehab and to better support specialized population (i.e., Failure to Cope)
	  • Choosing Wisely (e.g., polypharmacy, inappropriate Antipsychotic prescribing)

Opportunities for innovative service delivery

Innovative service delivery and improved access to care can be achieved through digital technology, including associated information and technology requirements, as well as integrated support services including diagnostics, patient transport, Emergency Services, infrastructure and equipment. The table below highlights key elements for the Seniors and Rehabilitation PCT as they are unique to those outlines in the Provincial chapter. Further, Key Performance Indicators have been outlined to assess the implementation of this model.

Digital Health	• Leverage telehealth and virtual care tools to support consultation, assessments, and treatments where feasible to share expertise across the Network and improve access to care
Diagnostic Services	• Coordinated diagnostic services available in Local and District Hubs to reduce patient transports
EMS/Patient Transport	• Patient transport requirements will need to consider the increased needs of older adults and rehab patients who will be returned to community earlier in their recovery, as well as the most appropriate type of transportation services
Infrastructure and Equipment	• Future infrastructure requirements will need to align with the seniors and rehab model of care and incorporate sub-acute care units to reduce LOS and provide care closer to home – sub-acute units will provide transitional care, convalescent care, rehabilitation, and others • Available equipment across settings of care will need to be considered to ensure smooth transitions into the community (e.g., accommodation for bariatric needs)
Prevention	• Provincial prevention strategies will be used to prevent older adults and rehab related admissions, for example falls prevention strategies (e.g., medication management to reduce risks of polypharmacy) and self-management prevention efforts post-rehabilitation

Key Performance Indicators

1. Improved quality and outcomes of seniors and rehabilitation care
2. Increased consistency in access to enhanced local hubs and core local hub services
3. Reduced ALC days for home care and PCH
4. Expanded capacity for home care – both medical/consultative as well as rehabilitative/restorative (e.g., in-person or virtual home-based care)
5. A one-third reduction in the number of older adults who reside in PCH, and shifting them to the community with ongoing supports
6. Skill building programs (FIP, HIM, Priority Home, elder-friendly care) expanded to all regions contributing to reduced acute LOS